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SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST
EXECUTIVE SUMMARY
REPORT TO THE PUBLIC BOARD OF DIRECTORS
HELD ON 31 JULY 2018

Subject:	Trust Access Policy
Supporting TEG Member:	Kirsten Major, Deputy Chief Executive
Authors:	Balbir Bhogal, Performance and Information Director
Status[1]	A*

PURPOSE OF THE REPORT:

To present the revised Trust Access Policy in line with changes recommended by the Intensive Support Team (IST).

KEY POINTS:

- The IST has reviewed the Trust Access Policy and provided feedback on areas that require attention.
- The IST has also issued an exemplar policy that can guide the Trust on what should be included within the policy.
- The Trust Policy has been updated following the IST feedback received and has been enhanced to reflect the best practice outlined in the exemplar policy.

IMPLICATIONS[2]**:**

AIM OF THE STHFT CORPORATE STRATEGY 2017-2020		TICK AS APPROPRIATE
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	

RECOMMENDATION(S):

To ratify the revised Trust Access Policy

APPROVAL PROCESS:

Meeting	Date	Approved Y/N
Clinical Management Board	25 May 2018	Y
Trust Executive Group	4 July 2018	Y
Board of Directors	31 July 2018	

Trust Access Policy

1. Introduction

The report shares the revised Trust Access Policy in line with changes recommended by the Intensive Support Team (IST).

2. Background

The Trust Access Policy was reviewed by the IST in March 2017 and feedback was received during July 2017. On a scale of 1-5 (5 being the best score) the policy was rated as a 2 with the supporting narrative of - requires partial re-write: specific amendments required, policy otherwise sound.

The areas of the policy requiring particular attention were;

- The management of DNA's
- Patient cancellations
- Patient initiated delays

3. Updated Policy

All areas of concerns highlighted by the IST have been addressed in the updated policy The exemplar policy has been used further to enhance the diagnostic waiting times section and therapy pathways guidance**.**

4. Policy consultation

The updated policy has been shared internally through the Elective Care Working Group, Waiting Performance Overview Group, Operations Directors and the Clinical Management Board.

It has been shared with the CCG and the Accountable Care System Elective Care Workstream and comments have been reviewed and incorporated where appropriate.

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

ACCESS POLICY

Management of Waiting Times including referral to treatment, cancer and diagnostic waits

Reference Number	Version	Status	Executive Lead(s) Name and Job Title	Author(s) Name and Job Title
216	5.0	Current	Kirsten Major, Deputy Chief Executive	Balbir Bhogal, Performance and Information Director

Approval Body	Clinical Management Board	**Date Approved**	25/05/2018
Ratified by	Board of Directors	**Date Ratified**	
Date Issued		**Review Date**	
Contact for Review Name and Job Title: Balbir Bhogal, Performance and Information Director			

Associated Documentation:

Trust Controlled Documents

Safeguarding Children Policy (June 2015)
Safeguarding Vulnerable Adults and Children's Policy (April 2015)
Equality Impact Analysis Policy (January 2012)

External Documentation

https ://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf
https ://www.gov.uk/government/publications/the-handbook-to-the-nhs-constitution-for-england

Legal Framework

NHS Constitution

For more information on this document please contact:-

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Version History

Version	Date Issued	Brief Summary of amendments	Owner's Name:
3.0	21/04/2015		Annette Peck
4.0	29/04/2016	National guidance changes reflected and procedural detail removed to be incorporated into a supporting Standard Operating Procedure	Balbir Bhogal/ Annette Peck
5.0	TBC	National exemplar policy issued	Balbir Bhogal

Executive Summary

ACCESS POLICY - Management of Waiting Times including referral to treatment, cancer and diagnostic waits

Document Objectives:	To ensure that all patients that are referred and treated within the Trust receive high quality care, fair and equitable access and services in line with 18 week Referral to Treatment, the Cancer Waiting Time Standards, diagnostic waiting times and the NHS Constitution. To provide the Trust with a coherent approach to the management of waiting lists, scheduling and booking across the organisation.
Group/Persons Consulted:	Clinical Management Board Trust Executive Group All Service Managers NHS Sheffield Clinical Commissioning Group
Monitoring Arrangements and Indicators:	Annual Review of policy Quarterly Review of adherence to the policy
Training Implications:	All staff involved in the 18 weeks Referral to Treatment Time pathway will receive training on 18 week pathways through a variety of learning packages Further training on the application of the policy will be provided to Service Managers, who will be required to train staff within directorates
Equality Impact Assessment:	Completed Equality Impact Assessment is included in the policy at Appendix 2
Resource implications:	Staff time for training and monitoring
Intended Recipients: Who should:-	
➢ be **aware** of the document and where to access it	All TEG members
➢ **understand** the document	All relevant Clinical Staff All Operations Directors , Nurse Directors , Clinical Directors and Service Managers
➢ have a **good working knowledge** of the document	All administrative and managerial staff involved in the recording and management of patient pathways All staff involved in arranging appointments and admission dates for patients

1.0 INTRODUCTION

1.1 Purpose of the policy

This Access Policy is intended to ensure that all patients that are referred and treated within the Trust receive high quality care, fair and equitable access and services in line with 18 week Referral to Treatment (RTT), the Cancer Waiting Time Standards, diagnostic waiting times and the NHS Constitution.

This policy will provide the Trust with a coherent approach to the management of waiting lists, scheduling and booking across the organisation. It will ensure that patients are treated in line with local and National Policies regarding Vulnerable Adults, Patients with Learning Disabilities, Safeguarding Children Policies and War Veteran Guidance.

Every process in the management of patients who are waiting for treatment must be clear and transparent to the patients and to partner organisations and will be open to inspection, monitoring and audit. The Trust will give priority to clinically urgent patients and treat everyone else in turn.

The policy reflects the key access targets for Outpatient, Inpatient, Diagnostic and Planned Waiting List Management, 18 Week RTT, and Cancer Waiting Time Standards, in line with the NHS Constitution.

The NHS Constitution describes what staff, patients and public can expect from the NHS. As well as capturing the purpose, principles and values of the NHS.

It clearly sets out a series of pledges and rights stating what patients, the public and staff can expect from the NHS. A patient has the right to the following:

- The choice of hospital and consultant.

- To commence their treatment for routine conditions following a referral into a consultant-led service, within a maximum waiting time of 18 weeks to treatment.
- To be seen by a cancer specialist within a maximum of two weeks from a GP referral for urgent referrals where cancer is suspected.

If this is not possible, the NHS has to take all reasonable steps to offer a range of alternatives.
The right to be seen within the maximum waiting times does not apply:

- If the patient chooses to wait longer.
- If delaying the start of the treatment is in the best clinical interests of the patient
  (Note that in both of these scenarios the patient's RTT clock continues to tick)

- If it is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage.

The policy will be continuously reviewed reflecting any changes in light of patient feedback, the intentions of the local Commissioners and NHS Constitutional rights and pledges.

It provides a framework within which detailed operational procedures can be formed at Directorate level to ensure access to services for outpatients, inpatient and day cases in the context of the 18

week RTT standard. The policy combines an interpretation of national guidance with local standards of productivity and equity such that waiting is minimised and activity is maximised.

Compliance with this policy will ensure:

- A streamlined patient pathway with minimum waits
- Trust adherence to mandated milestones and standards of measurement relating to elective patient pathways
- Consistent and equitable treatment of patients on elective pathways
- Effective use of Trust resources

Primary Care, hospital Clinical Staff, Managers, Secretarial and Clerical Staff all have an important role in managing the process of RTT effectively. The core responsibilities of the Trust and wider health community include:

- Treating patients in a timely manner
- Keeping hospital visits to the minimum required
- Delivering high quality, efficient and responsive services
- Prompt and informative communications with patients

This policy details how elective patients will be managed administratively at all points of contact with the Sheffield Teaching Hospitals NHS Foundation Trust (STHFT). It is the responsibility of all associated members of staff to understand the RTT principles and definitions.

Competency

- As a key part of their induction programme, all new starters to the Trust will undergo mandatory contextual elective care training which is applicable to their role.
- Staff involved in the RTT pathway will undergo mandatory contextual elective care training on at least an annual basis.
- Competency tests will be undertaken for all staff and clearly documented to provide evidence that the required level of knowledge and ability has been attained.
- This policy, along with the supporting suite of Standard Operating Procedures (SOPs), will form the basis of contextual training programmes (refer to the trust's Elective Care Training Strategy for more information).

Compliance

- Functional teams, specialties and staff will be performance managed against key performance indicators (KPIs) applicable to their role. Role specific KPIs are based upon the principles within this policy and specific aspects contained within the Trust's SOPs

In the event of non-compliance, a resolution should initially be sought by the team, specialty or individual's line manager. The matter should then be dealt with via the trust's disciplinary or capability procedure as appropriate.

There are a series of SOPs to support this policy.

The trust is committed to promoting and providing services which meet the needs of individuals and does not discriminate against any employee, patient or visitor.

1.2 Roles and responsibilities

- Operations Directors are accountable for implementing, monitoring and ensuring compliance with the policy in their Care Groups.
- The Information Team is responsible for the timely production of Patient Tracking Lists (PTLs) which support the Care Groups in managing waiting lists and RTT standards.
- Administrative staff including clinic clerks, administrators etc. are responsible to the Operations Directors with regard to compliance of all aspects of the elective Access Policy.
- GPs and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred.
- The CCGs are responsible for ensuring robust communication links are in place to feedback information to GPs. GPs should ensure quality referrals are submitted to the appropriate provider first time.
- The NHS Constitution recommends the following actions patients can take to help in the management of their condition:
    - Patients can make a significant contribution to their own, and their families, good health and wellbeing, and should take personal responsibility for it.
    - Patients should be registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies.
    - Patients should provide accurate information about their health, condition and status.
    - Patients should keep appointments, or cancel within a reasonable time frame

2.0 KEY PRINCIPLES

The principle underlying the maximum 18 week RTT standard is that patients should receive excellent care without unnecessary delay. The Trust will meet and improve on the maximum waiting times set by the DH for all groups of patients. This policy is intended to cover all non-emergency services provided by the Trust.

Every process in the management of patients who are waiting for treatment must be clear and transparent to staff, to patients and to partner organisations, and must be open to inspection, monitoring and audit, as required.

Patients should not be referred for acute services unless they are fit, ready and willing to access services within a maximum of 18 weeks. Primary care and secondary care need to work together to ensure that there are appropriate referral thresholds in place. The only exception to this is if the patient requires urgent treatment.

The Trust will negotiate appointment and admission dates and times with patients. 'Reasonableness' is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as a choice of two dates with at least three weeks' notice.

The Trust will work to ensure fair and equal access to services for all patients. All trusts have an obligation to identify patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with Department of Health guidance / rules.
The Trust will check every patient's eligibility for treatment. Therefore, at the first point of entry, patients will be asked questions which will assist the Trust in assessing 'ordinarily resident status'.

Some visitors from abroad, who are not ordinarily resident, may receive free healthcare such as those that:

- Have paid the immigration health surcharge.
- Have come to work or study in the United Kingdom.
- Have been granted or made an application for asylum.

Citizens of the European Union (EU) that hold a European Health Insurance Card (EHIC) are also entitled to free healthcare, although the trust may recover the cost of treatment from the country of origin. All staff have a responsibility to identify patients who are overseas visitors and to refer them to the Overseas Visitor's Office for clarification of status regarding entitlement to NHS treatment before their first appointment is booked or date to come in (TCI) agreed.

All patients must be seen primarily in order of length of wait, with the exception of war pensioners and service personnel injured in conflict, who must receive priority treatment if their condition is directly attributable to injuries sustained in conflict. Clinically urgent patients are defined as those who, for clinical reasons, cannot wait for the current maximum waiting times and need to be seen by the Consultant in no more than 2 weeks from referral for outpatients and operated on within 31 days from decision to treat for inpatients. Those patients prioritised as clinically urgent by the Consultant will be seen within these timescales rather than the standard maximum 18 week pathway in place for patients clinically prioritised as routine.

All elective standards and rules are applicable to prisoners. Delays to treatment incurred as a result of difficulties in prison staff being able to escort patients to appointments or for treatment should not affect the recorded waiting time for the patient and in this scenario the patient's RTT clock continues to tick.

The Trust will work with staff within the prison services to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonableness criteria.

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary by a private clinician the patient can be added directly to the elective waiting list if clinically appropriate. The RTT clock starts at the point the GP or original referral arrives in the hospital.

The RTT pathways of patients who notify the Trust of their decision to seek private care will be closed with a clock stop applied on the date of this being disclosed by the patient.

All referrals, additions and removals from all waiting lists will be made in accordance with this policy.

All waiting lists for outpatient appointments and hospital admission should be held on and managed through the Lorenzo Electronic Patient Record (EPR). Waiting lists for diagnostic tests and Allied Health Professionals can be held on local Information Technology (IT) systems but the principles of this policy must be applied. Manual (paper) waiting list management systems are not acceptable for any stage of the pathway.

The accuracy and reliability of waiting list and diagnostic information is the responsibility of **all staff** who are involved in the processing and management of outpatient referrals, diagnostics and admissions to the hospital.

A clinician will refer directly to another clinician in the following cases:

- Referrals that are part of the continuation of investigation / treatment of the same condition for which the patient was referred. This includes referrals to pain management where surgical intervention is not intended.
- Urgent referral for a new condition
- Suspected cancer referral. This will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days of the date the referral was received by consultant.

Patient information will be checked at every visit to ensure that Lorenzo EPR has the most up to date demographic information.

3.0 WAITING TIME GUARANTEES

The current national waiting time guarantees fall into three areas:-

Referral to treatment time (maximum18 weeks)
Waiting times for Cancer treatment
Waiting time for diagnostic tests

In addition the Trust has local standards for the waiting time for the stages of treatment.

3.1 Referral to Treatment

All patients should receive their first definitive treatment within 18 weeks of referral to secondary care.

The performance of the Trust against this standard is required to be:-

- **A minimum of 92% of patients who are still waiting for treatment in any period (incomplete pathways) should have waited less than 18 weeks – Nationally reported standard**

While the aim is to treat all elective patients within 18 weeks, the national elective access standards are set at less than 100% to allow for the following scenarios:

- **Clinical exceptions** – situations when it is in the patient's best clinical interest to wait more than 18 weeks for their treatment.
- **Choice** – when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments, or rescheduling previously agreed appointment dates / admission offers, or specifying a future date for appointment/admission.
- **Co-operation** – when patients do not attend previously agreed appointment dates or admission offers and where this prevents the Trust from treating them within 18 weeks.

- **A minimum of 90% of admitted patients complete their pathway within 18 weeks – Locally reported standard**

- **A minimum of 95% of non-admitted patients complete their pathway within 18 weeks – Locally reported standard**

3.2 Waiting time for Cancer Treatment

The target waiting times for patients where cancer is suspected, diagnosed or being treated are as follows:

i) All referrals from GP/GDPs (General Dental Practitioners) that are marked 'urgent suspicious of malignancy' must be seen by a specialist within 14 days of the date that the referral is received by the Trust. These are known as '2 week waits' (2ww).

ii) All referrals from GP/GDPs that are marked 'urgent suspicious of malignancy' where the diagnosis of cancer is confirmed will receive their first definitive treatment within 62 days of the date that the referral is received by the Trust.

iii) All other patients diagnosed with cancer who require treatment must receive that treatment within 31 days of the decision to treat being made.

iv) All patients diagnosed with cancer will wait no more than 31 days from decision to treat to the start of treatment for their second and subsequent treatment (surgery and chemotherapy).

v) All patients with suspected cancer, detected through national screening programmes must not wait more than 62 days from RTT.

vi) All patients where cancer is detected during their hospital care must not wait more than 62 days for treatment (Consultant upgrade) from the date that it is decided that cancer is a possible diagnosis.

The performance of the Trust against these standards is required to be:-

- 93% of referrals from GP/GDPs that are marked 'urgent suspicious of malignancy' will be seen within 2 weeks

- 85% of referrals from GP/GDPs that are marked 'urgent suspicious of malignancy' where the diagnosis of cancer is confirmed will receive their first definitive treatment within 62 days

- 96% of all other patients diagnosed with cancer who require treatment must receive that treatment within 31 days of the decision to treat being made.

- 94% of patients diagnosed cancer patients will wait no more than 31 days from decision to treat to the start of treatment for second and subsequent treatment of surgery or radiotherapy.

- 98% of patients diagnosed cancer patients will wait no more than 31 days from decision to treat to the start of treatment for second and subsequent treatment of chemotherapy.

- 90% of patients with suspected cancer, detected through national screening programmes will wait no more than 62 days from referral to treatment.

- 85% of patients where cancer is detected during their hospital care will wait no more than 62 days for treatment (Consultant upgrade) from the date that it is decided that cancer is a possible diagnosis.

3.3 Waiting Times for Diagnostic Tests

The overall diagnostic waiting times performance is made up of a total of 15 different diagnostic tests.

- The national target is that 99% of patients will have their diagnostic test within 6 weeks of referral. The local standard is 4 weeks.

All referrals for diagnostic tests must wait no longer than the national standard of 6 weeks with the majority being seen within the local standard of 4 weeks.

3.4 Straight to test diagnostics

Where a GP/AHP requests a diagnostic test to determine whether onward referral to secondary care or management in primary care is appropriate, then the patient is not on an 18 week RTT pathway and the RTT clock does not start.

The patient must have the diagnostic procedure within six weeks of referral. If the patient is subsequently referred to secondary care, then an RTT pathway will commence on the date the referral for that care is received.

Where a GP refers a patient for a diagnostic test prior to an Outpatient appointment with a Consultant as part of an agreed pathway, i.e. it is known that the patient will require a Consultant appointment, then the patient is on an 18 week RTT pathway and the clock starts on receipt of the referral to the Consultant. The national standard is that a patient must wait no longer than six weeks for their diagnostic procedure. The local standard is 4 weeks.

3.5 Patients requiring commissioner approval

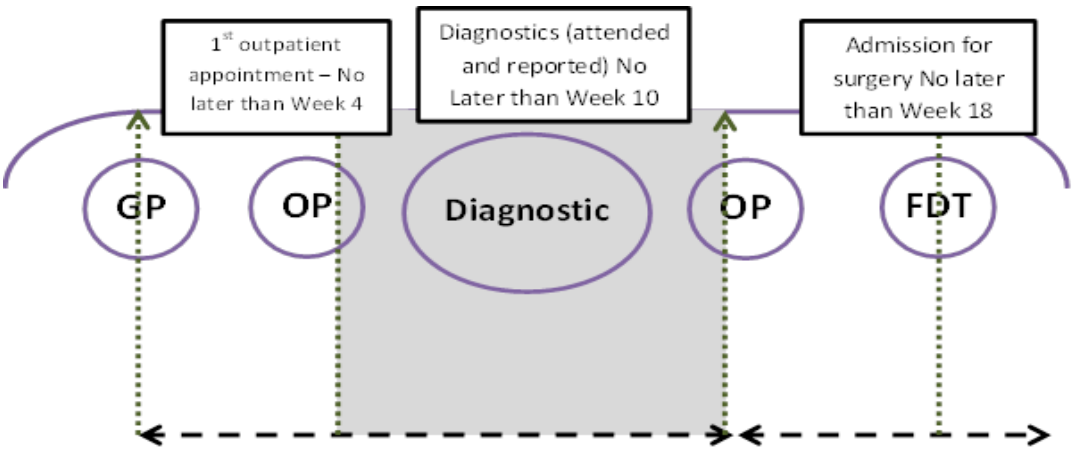
Once the patient has been referred to secondary care and a RTT pathway started, clock stops can only be made to a patient's RTT pathway when treatment occurs or a decision not to treat is made. No adjustments or clock stops can be made to a pathway whilst a panel or approval board assesses commissioner approval requests. Patients who require treatment which must have commissioner approval prior to commencement must not be disadvantaged by having their referral returned to primary care. Therefore, the referrer to the Trust must seek prior approval before referring the patient. The approval must accompany the referral. The Trust will operate in accordance with the guidance as outlined in the CCG's prior approval policies and procedures. See link to Procedures of Limited Clinical Value SOP

In some instances it will not be apparent until the outpatient consultation or on completion of diagnostic testing, that the patient requires an excluded procedure. Commissioners should hold approval panels in line with the 18 week timeframes for any patient referred for assessment who has already commenced an RTT pathway.

For cancer referrals, Commissioners should hold approval panels in line with the cancer waiting times framework.

4.0 18 WEEK REFERRAL TO TREATMENT

The diagram below provides a visual representation of the chronology and key steps of a typical local RTT pathway.



4.1 Start of the 18 Week Pathway

4.1.1 An 18 week clock starts when any healthcare professional refers to:-

(i) A consultant led service, regardless of location, with the intention that the patient will be assessed and if appropriate, treated before responsibility is transferred back to the referring healthcare professional (usually GP or GDP).

(ii) A referral management or assessment service, that may result in an onward referral to a consultant led service before responsibility is transferred back to the referring healthcare professional (usually GP or GDP).

4.1.2 An 18 week clock also starts when:-

(i) A new decision to treat is made for a patient currently receiving ongoing care at the hospital. For example, a patient has been prescribed medication that is intended to treat their condition and is followed up in an outpatient setting. When the patient attends for a routine review, their condition has changed and an intervention is required. A new 18 week pathway period starts when the decision to admit (DTA) is made.

(ii) A referral is made by a consultant either within the hospital or from another provider to a consultant led service for a new course of treatment. For example, a patient has been managed conservatively in a medical specialty but their condition deteriorates and surgical intervention is required. A new 18 week pathway starts when the referral to the surgical specialty is made.

(iii) When a patient becomes fit and ready for the second of a bilateral procedure, for example a cataract operation on the second eye. A new 18 week pathway starts when the patient is fit to be treated and returned to the 'active' waiting list.

A referral to most consultant-led services will start an RTT clock. However, the following services and types of patients are excluded from RTT:

- Obstetrics and midwifery
- Planned patients
- Referrals to a non-consultant led service
- Non-English commissioners
- Sexual health services
- Emergency pathway non-elective follow-up clinic activity.

4.2 End of the 18 Week Pathway

The 18 week pathway ends when:-

(i) The patient receives their first definitive treatment that is 'treatment that is intended to manage their disease, condition or injury'. The clock stops if the treatment given is intended to avoid further intervention. Treatment will often continue beyond the first definitive treatment and after the clock has stopped.

(ii) The patient declines treatment.

(iii) When a diagnosis has been reached but either the patient or the clinician decide that rather than treatment, a period of time where the condition is monitored on a regular basis in secondary care is appropriate. This is termed 'active monitoring'. The patient remains under the care of the hospital during this period and must be actively followed up. A patient on active monitoring should either, be on a 'planned' waiting list, be on the outpatient review list with a scheduled review date, or have a future outpatient appointment booked. If a decision is made that treatment is now appropriate then a new period on the 18 week pathway is created and a new 18 week clock is started.

(iv) A patient is added to a transplant waiting list.

(v) A decision is made that no treatment is required or the patient is not ready for treatment and the patient is discharged back to primary care (usually GP or GDP).

(vi) Patient has treatment as an emergency which was previously intended to be done electively.

4.3 Patient Initiated Delays

4.3.2 Cancelling, declining OR delaying appointment and admission offers

Patients can choose to postpone or amend their appointment or treatment if they wish, regardless of the resulting waiting time. Such cancellations or delays have no impact on reported RTT waiting times as the clock continues. However, clinicians will be informed of patient initiated delays to ensure that no harm is likely to result from the patient waiting longer for treatment (clinicians may indicate in advance, for each specialty or pathway, how long it is clinically safe for patients to delay their treatment before their case should be reviewed). Where necessary, clinicians will review each and every patient's case on an individual basis to determine whether:

- The requested delay is clinically acceptable (clock continues)
- The patient should be contacted to review their options – this may result in agreement to the delay (clock continues) or to commence a period of active monitoring (clock stops)

- The patient's best clinical interest would be served by discharging them to the care of their GP (clock stops)
- The requested delay is clinically acceptable but the clinician believes the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patient's treatment plan-active monitoring (clock stops).

The general principle of acting in the patient's best clinical interest at all times is paramount. It is generally not in a patient's best interest to be left on a waiting list for an extended period, and so where long delays (i.e. of many months) are requested by patients then a clinical review should be undertaken, and preferably the treating clinician should speak with the patient to discuss and agree the best course of action. Patients should not be discharged to their GP, or otherwise removed from the waiting list, unless it is for clinical reasons.

4.4 Patients Who Are Unfit for Surgery

If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained.

Short-Term Illnesses

If the clinical issue is short-term and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold), the RTT clock continues.

Longer Term Illnesses - If the nature of the clinical issue is more serious for which the patient requires optimisation and treatment, clinicians should indicate to administration staff:

- If it is clinically appropriate for the patient to be removed from the waiting list. This will be a clock stop event via the application of active monitoring. The patient will be managed via outpatients or referred back to the GP whichever is deemed the most clinically appropriate action for the patient
- If the patient should be optimised or treated within secondary care (active monitoring clock stop) or if they should be discharged back to the care of their GP (clock stop).

5.0 NON ADMITTED PATHWAYS

5.1 REFERRALS

The primary route for the receipt of referrals will be electronically through e-Referral Service (eRS), formerly Choose and Book (C&B). However, in the short term referrals will also be received:-

- Electronically through NHS mail for tertiary referrals (inter provider transfers)
- On paper for referral from GPs (post or fax). From the 1st May 2018 paper referrals from GPs for consultant led services will not be accepted in line with the standard NHS contract terms.
- On paper for tertiary referrals (inter provider transfers)

5.1.1 Referrals received through e-Referral Service (eRS)

- Patients who have been referred via e-RS should be able to choose, book and confirm their appointment prior to the Trust receiving and accepting the referral.
- If there are insufficient slots available for the selected service at the time of attempting to book (or convert their UBRN), the patient will appear on the Appointment Slot Issue (ASI) work list. The

RTT clock starts from the point at which the patient attempted to book. Patients on the ASI list must be contacted within two working days by the central booking office to agree an appointment.

- If a patient's appointment has been incorrectly booked on the NHS e-Referral system into the wrong service at the Trust by the referrer, the referral should be electronically re-directed in the e-Referral system to the correct service. A confirmation letter of the appointment change will be sent to the patient. The patient's RTT clock will continue to tick from the original date when they converted their UBRN.

5.2 Inter Provider Transfers received through NHS mail

All IPT referrals will be received electronically via the trust's secure generic NHS net email account in the central booking office.

The trust expects an accompanying Minimum Data Set (MDS) pro-forma with the IPT, detailing the patient's current RTT status (the Trust will inherit any RTT wait already incurred at the referring trust if they have not yet been treated) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this trust). The patient's pathway identifier (PPID) should also be provided. If the IPT is for a diagnostic test only, the referring trust retains responsibility for the RTT pathway. If any of the above information is missing, the referral should be recorded on PAS and the information actively chased by the central booking office.

For cancer patients, the Trust will expect the South Yorkshire and Bassetlaw Cancer Alliance IPT requirements to be adhered to. Link to IPT guidance

5.3 Paper Referrals

All referral letters both those from GPs and tertiary referrals should be stamped with the date of receipt and entered onto Lorenzo EPR within 1 working day of receipt.

The referral should be graded by clinical staff, if required, and returned to clinic booking staff within 2 days of receipt of the referral.

From the 1st May 2018 the Trust will no longer accept paper referrals from GPs. The GP will be notified and asked to use the national eRS system. From the 1st October 2018 paper referrals from GPs will be rejected.

5.4 Misdirected Referrals

If a referral has been made to a named consultant and the special interest of the consultant does not match the needs of the patient, the consultant should not see the patient but pass the referral on to an appropriate colleague. The Trust reserves the right to re-allocate referrals appropriately within a specialty to ensure fair and equitable access to patients.

If a patient has booked an appointment using the eRS system but the receiving consultant or service judge that it would be better if the patient was seen in a different clinic/service then the appointment will be re-scheduled into an appropriate clinic using the eRS system with the minimum possible inconvenience to the patient. Only in exceptional circumstances should the appointment be booked outside of eRS. The referrer will be informed of the change via the eRS work lists.

5.5 Advice and Guidance

GPs may contact the Trust to seek advice and guidance. This may result in clinical teams advising tests, a formal referral or other advice. A referral for advice and guidance does not start an 18 week

pathway. Referrals for advice and guidance must be made via eRS and actioned within 48 hours of receipt of the request.

5.6 Consultant to consultant referrals

Referrals from consultant to consultant are permitted under the following conditions;

- Referrals that are part of the continuation of investigation / treatment of the same condition for which the patient was referred. This includes referrals to pain management where surgical intervention is not intended.
- Urgent referral for a new condition
- Suspected cancer referral. This will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days of the date the referral was received by consultant.

5.7 Clinical Assessment and Triage Services (CATS) & Referral Management Centres (RMCs) & CASES

A referral to a CATS, RMC or CASES (Primary Care Sheffield) starts an 18 week RTT clock from the day the referral is received in the CASES service/ CAT / RMC. If the patient is referred on to the Trust having not received any treatment in the service, the Trust inherits the 18 week RTT wait for the patient.

- A Minimum Data Set (MDS) form must be used to transfer 18 week information about the patient to the Trust.

5.8 Outgoing IPTs

- The Trust will ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway.
- An accompanying Minimum Data Set (MDS) proforma will be sent with the IPT, detailing the patient's current RTT status (the receiving trust will inherit any RTT wait already incurred if the patient has not yet been treated). If the patient has been referred for a new treatment plan for the same condition, a new RTT clock will start upon receipt at the receiving Trust. The patient's patient pathway identifier (PPID) will also be provided
- If the IPT is for diagnostic only, this Trust retains responsibility for the RTT pathway.
- Referrals and the accompanying MDS will be emailed securely from the referring specialty NHS net account to the STH generic central booking office NHS account. The central booking office will verify (and amend if necessary) the correct RTT status for the patient. If the patient has not yet been treated, the RTT clock will be nullified at referring Trust. They will then forward to the receiving Trust within one working day of receipt into the generic email inbox

6.0 OUTPATIENT APPOINTMENTS

6.1 Referrals for Cancer Services

To meet the required NHS standards, all referrals from GP/GDPs that are marked 'urgent and suspicious of malignancy' must be seen by a specialist **within 14 days of the referral being received by the Trust.** All specialties should have procedures in place to ensure that this standard is met.

The 'quality' of suspected cancer referrals needs to be subject to regular audit by clinicians, with appropriate feedback to individual GP/GDPs and as necessary to commissioners. If there is evidence of training needs in general practice in relation to cancer symptoms, or that this route is being abused to secure fast-track appointments for inappropriate patients, appropriate measures will be agreed with the commissioners.

Any concerns related to urgent cancer referrals should be pursued with the Operational Director and Cancer Management Group who will agree a course of action with the GP Lead Clinician for Cancer.

For urgent cancer referrals, where the appointment has not been made through eRS the patient should be contacted as soon as possible, preferably by phone and an appointment date agreed.

If it is necessary to rearrange the appointment then the patient must be contacted by phone and a new date agreed. Appointments must not be rearranged without agreeing the new date with the patient.

6.2 Referrals other than Cancer

All referrals other than cancer and those not made using the eRS will be date stamped with the date the letter is received in the Directorate and entered on to Lorenzo EPR within 1 day of receipt. This must be done before the letter is forwarded for clinical grading. When a clinician determines that an urgent appointment is needed attempts should be made to agree a date with the patient within 14 days of the referral being received. All other referrals should be seen in chronological order.

An appointment date will then be agreed with the patient. The date of all new appointments must be agreed with the patient and recorded as such on Lorenzo EPR. This also applies to appointments rearranged by the hospital. All patients must receive at least 7 days' notice of all appointments. If it is necessary to rearrange the appointment then the patient must be contacted by phone and a new date agreed. Appointments must not be rearranged without agreeing the new date with the patient.

6.3 Patients who do not attend an Outpatient Appointment

6.3.1 Cancer Referrals – New Appointment

Patients referred under the cancer two-week wait standard that are given an appointment and subsequently DNA must be contacted by telephone as soon as possible and one further urgent appointment agreed. The process outlined below for checking the patient's address should be followed. If the patient fails to attend the second appointment, clinical review should be undertaken and if a decision is made not to re-appoint then the GP should be notified as soon as possible. No further appointments will be offered until advised by the GP. If the referral is from another acute provider then the referring clinician will also be informed

6.3.2 Cancer Referrals – Follow up (subsequent) Appointment

If a patient referred under the cancer two-week wait standard does not attend a follow up outpatient appointment then they should be contacted by telephone and given another appointment as soon as possible. The process outlined below for checking the patient's address should be followed. If they DNA this second appointment then they should be clinically reviewed and if a further appointment is not felt clinically appropriate, the patient should be referred back to their GP and no further appointments offered until advised by the GP. If the referral is from another acute provider then the referring clinician will also be informed.

6.3.3 Referrals for patients under the age of 18 years – New and Follow up Appointment

As part of safeguarding and multi-agency working, any child or young person aged 0 to 17 years (up to their 18th birthday) who fails to attend a designated appointment will have this communicated to the named consultant, and if appropriate to the registered GP/Health Visitor/ School Nurse/Social Worker, by the clinic nurse or allied health professional

When a child or young person does not attend an appointment in an outpatient clinic/department/ diagnostic or therapeutic services, the clinic nurse, allied health professional or designated member of the team must make a follow up phone call to the parent/carer on the same working day when possible or within 24 hours to establish the reason for non-attendance. If the young person is aged 16 years and above the contact should be made with the patient directly (except if the patient has a recognised disability). The detailed requirements are set out in the 'Guidance for the Follow Up of Children and Young People who Fail to Attend an Out Patient Appointment' (Children's DNA policy).

6.3.4 Other Referrals – New Appointment

Non-attendance of appointments / did not attend (DNA)

Other than at first attendance, DNAs have no impact on reported waiting times. Every effort should be made to minimise DNAs, and it is important that a clinician reviews each and every DNA on an individual patient basis.

If a patient does not attend a new appointment then the patient's address that is held on Lorenzo EPR should be verified, either by contacting the patient's GP or by accessing their record on the Summary Care Record. If the address on Lorenzo EPR is not the most up to date one then the patient should be contacted by telephone and a further appointment made within 7 days. If the patient's address is correct then the patient should be clinically reviewed and if not re-appointed the patient should be referred back to their GP and no further appointments offered until advised by the GP. If the referral is from another acute provider then the referring clinician will also be informed.

When informing the patient's GP/GDP of the failure to attend it is important to point out any risks or vulnerabilities that the patient may be subject to and that the GP/GDP may be unaware of that could be exacerbated by the non-attendance. Where necessary this should extend to a request for intervention by the GP/GDP which may lead to a further referral. This is a clinical responsibility of the Consultant responsible for their care.

6.4 Patients Who Change an Outpatient Appointment

6.4.1 Cancer Referrals

Patients who contact the hospital to change their outpatient appointment should agree an alternative appointment at the time of cancellation. If the patient cancels their appointment on more than two occasions then they should be told that if they cancel the appointment again then they may be discharged back to the care of their GP following clinical review i.e. if they cancel three consecutive appointments. If the referral is from another acute provider then the referring clinician will also be informed.

6.4.2 Referrals for patients under the age of 18 years

If a parent/carer or the young person cancels a clinic appointment this must be documented in the patients notes by the clinic nurse or allied health professional or recorded electronically via Radiology

Information System (CRIS) for diagnostic services. Clerical staff must be made aware to report any cancelled or outstanding appointments on eRS to the clinic nurse or allied health professional. The notes must be shown to, or discussed with the patient's named consultant who will make the decision for reappointment. The detailed requirements are set out in the 'Guidance for the Follow Up of Children and Young People who Fail to Attend an Out Patient Appointment' (Children's DNA policy).

6.4.3 Other Referrals

If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not DNA.

- If the patient requires a further appointment, this will be booked with the patient at the time of the cancellation.
- If the patient is on an open RTT pathway, the clock continues to tick. If there are insufficient appointment slots within the agreed pathway milestones, the issue must be escalated to the relevant speciality management team. Contact with patient must be made within two working days to agree an alternative date.

- If the patient has never been seen and advises they do not wish to progress their pathway, they will be removed from the relevant waiting list and a clock stop and nullification applied. The patient will be informed that their consultant and GP will be informed of this.

- If as a result of the patient cancelling, a delay is incurred which is deemed a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway should be reviewed by their consultant. Upon clinical review, the patient's consultant should indicate one of the following:

    - Clinically safe for the patient to delay - continue progression of pathway. The RTT clock continues.
    - Clinically unsafe length of delay – clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues.
    - Clinically unsafe length of delay – in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to GP.

6.5 Clinic Cancellation or Reduction

All staff holding clinics (including consultants) should provide as much notice as possible of any planned leave. Clinics will now be booked to 12 weeks and patient inconvenience and distress are minimised by staff providing as much notice of leave as possible. Consultants must give a minimum of 6 weeks' notice for planned leave and for any other staff holding clinics, the exigencies of the service will be interpreted as a minimum of 6 weeks' notice. There should not be any clinic cancellations or reductions for this reason without at least 6 weeks' notice. All clinic cancellations that are not the result of an authorised planned absence or are within less than 6 weeks must be reported by the Outpatient Manager/Supervisor to the Operations Director who will be expected to investigate the reason in consultation with the Clinical Director. It is important that clinic staff do not cancel or reduce clinics that are less than 6 weeks away without the authorisation of the Operations Director or Clinical Director.

- Where patients have to be cancelled, the case notes should be reviewed by the clinician concerned.

- Patients that have been previously cancelled by the hospital should not be cancelled a second time.

- An alternative appointment must be agreed with the patients who would have attended the cancelled or reduced clinic as soon as possible in line with clinical need.

Short notice cancellations must be an exceptional event as they are inconvenient for patients and could possibly lead to deterioration in their health. Clinical Directors and Operational Directors will be expected to monitor the cancellation reasons and to intervene if avoidable cancellations are indicated. Where cancellations are a regular feature, actions to reduce the frequency will be agreed for each specialty and progressive reductions over time will need to be demonstrated.

Any other changes to patients' appointments must be agreed with the patient and where possible 7 days' notice of the alternative given.

The practice of sending the patient a revised appointment without agreeing it with them or without making it clear that they can rearrange this appointment must not happen.

6.6 Follow up appointments

Many patients will not require a follow up appointment and will be discharged back to their referrer following their first assessment. When the clinician decides that a follow up appointment is necessary the GP should be informed and the letter should clearly state why the follow up is necessary.

If patients have not yet started treatments (i.e. they are on an open pathway) and a clinician indicates that a patient requires a follow up appointment then this date and time should be arranged and agreed with the patient before he/she leaves the outpatient clinic. This appointment must be such that the patient can still commence their treatment within 18 weeks.

If the patient has already started their treatment (i.e. is on a closed pathway) and the appointment is required within 12 weeks then this should be arranged with the patient before he/she leaves the outpatient clinic so that, the date and time can be agreed with the patient. If the appointment is required after 12 weeks then it can be arranged with the patient before they leave the outpatient clinic or the patient can be placed on a follow up outpatient waiting list with a date by when they should be seen. Patients should then be contacted at least 3 weeks before their due date and an appointment date agreed with them. All patients should be given at least 7 days notice of their appointment, unless in discussion they agree to attend at shorter notice, should an appointment be available.

If it becomes necessary to rearrange any appointments then the patient should be contacted and a new date and time agreed.

For vulnerable adults it is important that the arrangements for follow up appointments are agreed with their carer. These patients are identified on the PAS system. Some of these patients may find it difficult to deal with the Trust's administrative processes and if it is necessary to rearrange their appointment then it is essential that they and/or their carer's are contacted personally and not communicated with solely by letter.

6.7 Outcome of Outpatient Appointments

The outcome of all outpatient appointments should be recorded on Lorenzo EPR at the time of the clinic and the appropriate action should be taken (e.g. patient added to the inpatient or day case waiting list). The standard clinic outcome form is provided in Appendix 1. Patients should not be recorded as having an outcome of 'Open Appointment' but should be discharged back to their GP/GDP, unless there are exceptional clinical circumstances (e.g. patients in the terminal phase of their illness), which should be fully recorded in the patient record by the treating hospital clinician.

There are patients (such as those with spinal injuries) who require annual follow up. These should be placed on outpatient review lists and managed accordingly.

Upon attendance in clinic, patients may be on an open pathway (i.e. waiting for treatment with an RTT clock running) or they may already have had a clock stop due to receiving treatment or a decision not to treat being agreed. It is possible for patients to be assigned any one of the following RTT statuses at the end of their outpatient attendance, depending on the clinical decisions made or treatment given / started during the consultation:

Patients on an Open Pathway

- Clock stop for treatment
- Clock stop for non-treatment
- Clock continues if requiring diagnostics, therapies or being added to the admitted waiting list.

Patients already treated or with a decision not to treat

- New clock start if a decision is made regarding a new treatment plan.
- New clock start if the patient is fit and ready for the second side of a bilateral procedure.
- No RTT clock if the patient is to be reviewed following first definitive treatment.
- No RTT clock if the patient is to continue under active monitoring

Accurate and timely recording of these RTT statuses at the end of the clinic are therefore critical to supporting the accurate reporting of RTT performance.

7.0 DIAGNOSTIC TEST

7.1 Patients with a Diagnostic & RTT Clock

The diagnostics section of an RTT pathway is a major pathway milestone. A large proportion of patients referred for a diagnostic test will also be on an open RTT pathway. In these circumstances, the patient will have both types of clock running concurrently:

- Their RTT clock which started at the point of receipt of the original referral.
- Their diagnostic clock which starts at the point of the decision to refer for diagnostic test (often at the first outpatient consultation).

7.2 Straight to Test Arrangements

For patients who are referred for a diagnostic test where one of the possible outcomes is review and if appropriate treatment within a consultant led service (without first being reviewed by their GP) an RTT clocks will start on receipt of the referral. These are called straight to test referrals.

7.3 Patients with a Diagnostic Clock Only

Patients, who are referred directly for a diagnostic test (but not consultant-led treatment) by their GP i.e. clinical responsibility remains with the GP, will have a diagnostic clock running only. These are called Direct Access referrals. Patients may also have a diagnostic clock running only where they have had an RTT clock stop for treatment or non-treatment and their consultant refers them for a diagnostic test with the possibility that this may lead to a new RTT treatment plan.

7.4 National diagnostic clock rules

Diagnostic clock start – the clock starts at the point of the decision to refer for a diagnostic test by either the GP or the consultant.

Diagnostic clock stop – the clock stops at the point in which the patient undergoes the test.

7.5 Booking diagnostic appointments

Appointments will be booked in line with the locally agreed reasonableness criteria The appointment will be booked directly with the patient at the point that the decision to refer for a test was made, wherever possible (e.g. the patient should be asked to contact the diagnostic department by phone or face to face to make the booking before leaving the hospital).

If a patient declines, cancels or does not attend a diagnostic appointment, the diagnostic clock start can be reset to the date the patient provides notification of this. However:

- The Trust must be able to demonstrate that the patient's original diagnostic appointment fulfilled the reasonableness criteria for the clock start to be reset.
- Resetting the diagnostic clock start has no effect on the patient's RTT clock. This continues to tick from the original clock start date.

7.6 Diagnostic Cancellations, Declines and / or DNAs for Patients on Open RTT Pathways

Where a patient has cancelled, declined and / or not attended their diagnostic appointment and a clinical decision is made to return them to the referring consultant, the RTT clock should continue to tick. Only the referring clinician can make a clinical decision to stop the RTT clock, if this is deemed to be in the patient's best clinical interests.

7.7 Active Diagnostic Waiting List

All patients waiting for a diagnostic test should be captured on an active diagnostic waiting list, regardless of whether they have an RTT clock running, or have had a previous diagnostic test. The only exceptions are planned patients (see below).

7.8 Planned Diagnostic Appointments

Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons are exempt from the diagnostic clock rules and will be held on a Planned waiting list with a clinically determined due date identified. However, should the patient's wait go beyond the due by date for the test, they will be transferred to an active waiting list and a diagnostic clock and RTT clock will be started.

7.9 Therapeutic Procedures

Where the patient is solely waiting for a therapeutic procedure, for example in the radiology department, there is no six week diagnostic standard. However, for many patients there is also a diagnostic element to their admission / appointment, and so these patients would still be required to have their procedure within six weeks.

8.0 PRE-OPERATIVE ASSESSMENT

All patients with a decision to admit (DTA) requiring a general anaesthetic will attend a POA clinic on the same day as the decision to admit to assess their fitness for surgery. The vast majority of patients can be assessed by the trust's dedicated POA nurse specialists using the Trust's electronic pre-operative assessment questionnaire (EPAQ – PO).

- Patients should be made aware in advance that they may need stay longer on the day of their appointment for attendance in POA.

- For patients with complex health issues requiring a POA appointment with a nurse consultant, the trust will aim to agree this date with the patient before they leave the clinic. The trust will aim to agree an appointment no later than seven working days from the decision to admit.
- Patients who DNA their POA appointment will be contacted and a further appointment agreed. Should they DNA again, they will be returned to the responsible consultant. **The RTT clock continues to tick throughout this process.**

- If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained. If the clinical issue is **short-term** and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold, UTI), the RTT clock continues.

- However, if the nature of the clinical issue is more serious for which the patient requires optimisation and / treatment, clinicians should indicate to administration staff if it is clinically appropriate for the patient to be removed from the waiting list, and if so whether the patient should be:
    - Optimised / treated within secondary care (active monitoring clock stop for existing pathway and potentially new clock start for optimisation treatment) or
    - Discharged back to the care of their GP (clock stop – discharge).

When the patient becomes fit and ready to be treated for the original condition, a new RTT clock would start on the day this decision is made and communicated to the patient.

9.0 ACUTE THERAPY SERVICES

Acute therapy services consist of Physiotherapy, Dietetics, Orthotics and Surgical Appliances. Referrals to these services can be:

- Directly from GPs where an RTT clock would NOT be applicable
- During an open RTT pathway where the intervention is intended as **first definitive treatment** or **interim treatment**.

Depending on the particular pathway or patient, therapy interventions could constitute an RTT clock stop. Equally the clock could continue to tick. It is critical that staff within these services know if patients are on an open pathway and if the referral to them is intended as first definitive treatment.

- **Physiotherapy**

For patients on an orthopaedic pathway referred for physiotherapy as **first definitive treatment**-the RTT clock stops when the patient commences physiotherapy.

For patients on an orthopaedic pathway referred for physiotherapy as interim treatment (as surgery will definitely be required.)-the RTT clock continues when the patient undergoes physiotherapy.

- **Surgical Appliances**

Patients on an orthopaedic pathway referred for a surgical appliance with no other form of treatment agreed. In this scenario, the fitting of the appliance constitutes first definitive treatment and therefore the RTT clock stops when this occurs.

- **Dietetics**

If patients are referred to the dietician and receive dietary advice with no other form of treatment, this would constitute an RTT clock stop. Equally, patients could receive dietary advice as an important step of a particular pathway (e.g. bariatric)-in this pathway; the clock could continue to tick.

10.0. INPATIENT WAITING LISTS (Access Plans)

10.1 Adding Patients to the Waiting List for Admission

The decision to add a patient to a Waiting List must be made by a Consultant or a Clinician authorised to do so.

Patients who are added to the waiting list including booked admissions **must be,** in the opinion of the clinician, **clinically ready for admission on the day the decision to admit is made**. The clinician must determine that the patient is available and prepared to be admitted at any point within the remaining time to ensure that the 18 week RTT is honoured and that the patient would be well enough to proceed with the operation/procedure at any point within that time frame. The overriding principle should be if there was a bed available tomorrow for the patient, they would be fit, ready, and able to come in. The exception to this statement is patients on a cancer pathway.

10.2 Booked Patients

Whenever possible, a date for admission should be agreed with the patient at the time the decision to admit is made. If the patient requires pre-operative assessment then the appointment for the pre-assessment clinic should be made at the time the decision to admit is made. Patients who have an agreed date for admission will have their details added to the active waiting list with a booked to come in (TCI) date and they will be included in all statistical returns and monitoring. The agreed date should be within the 18 weeks RTT unless the patient chooses otherwise. If the patient chooses to delay their treatment then a patient pause should be recorded as described in section 12.2.

10.3 Confirmation to the Patient

Every patient should receive a letter confirming that they have been put on a waiting list or have agreed to a booked admission date. This should include details of how the patient can contact the Trust if they will not be able to accept an admission date during a particular time period.

If a Patient Information leaflet is available for the intended procedure this should be given to the patient in clinic or included with the letter (not both).

11.0 STRUCTURE OF WAITING LISTS

To aid both the clinical and administrative management of the waiting list, it is recommended that lists should be sub-divided into a limited number of smaller lists, differentiating between active lists and others.

11.1 Active Waiting Lists

The active waiting list should consist of patients awaiting admission who are available to come in or who have accepted a booked admission date.

Clinicians should decide how they wish to sub-divide their active waiting lists to assist them with the clinical management of patients, but these sub-divisions should be as few as possible.

11.2 Planned Waiting Lists

Planned waiting list patients are those who are waiting to be recalled to hospital for a known further stage in their course of treatment or investigation/intervention. These patients are not waiting for a first treatment date - they have commenced their treatment and there is a plan for the subsequent stages of that treatment.

Examples include:

- "Check" endoscopic procedures
- Age/growth related surgery
- Chemotherapy

Patients should only be on a planned list if there are clinical reasons why the patient cannot have the procedure or treatment until a specified time. Patients on planned waiting lists should not be on open 18 week pathways. There should be no patients on a planned waiting list for social reasons. All patients must have an expected admit date recorded on Lorenzo EPR.

When a patient on a planned list does not have their consultant-led treatment procedure on or around the planned date they should be transferred to an active list and an RTT clock should start i.e. an RTT clock should start if the due date for the planned consultant-led procedure is reached and the patient has not yet received treatment. Thereafter, 'normal' RTT rules should apply.

12.0 MAINTAINING THE WAITING LIST

Waiting lists should be kept up to date by the responsible person using data received from various sources. They need to ensure that patients are listed promptly and that the list does not contain patients who no longer need their operations at the hospital.

12.1 Computer Systems

To ensure consistency and the standardisation of reporting with Commissioners and the NHS Executive, **all waiting lists are to be maintained and managed using Lorenzo EPR. In no circumstances should duplicate manual waiting list records be held.**

Details of patients' who require inpatient or daycase admission must be entered onto the computer system within 2 working days of the decision to admit. Failure to do this will lead to incorrect assessment of where the patient is on the 18 week RTT and incorrect reporting of the waiting list size. The date of decision to admit must be the same as the clinic attendance date or the date the test results were received.

12.2 Patient Pauses

The process of suspending a patient on the waiting list is no longer permissible.

Some patients are not currently available for admission due to social/personal reasons, e.g. holidays, work commitments and may request that their admission be delayed. For the measurement of the 18 week RTT this delay has no effect on the patient's 18 week pathway, as the clock remains ticking, and the patient should still be treated within 18 weeks of their referral. Lorenzo EPR should be used to record patient availability. All periods of availability must have an end date.

12.3 Active Monitoring

Active monitoring is where it is clinically appropriate to monitor the patient in secondary care without clinical intervention or further diagnostic procedures. Active monitoring can be initiated by either the patient or the Clinician. The start of a period of active monitoring stops the RTT waiting time, a new clock starts from zero weeks wait at the end of the active monitoring period and the Trust has a further 18 weeks to treat the patient

Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made. If such a decision has been made but subsequently it becomes apparent that there is a clinical reason to delay treatment/admission then a waiting time clock would usually continue.

Stopping a patient's clock for a period of active monitoring requires careful consideration on a case by case basis and its use needs to be consistent with the patient's perception of their wait.

13. ARRANGING DATES FOR ADMISSION

13.1 Offers of Admission Dates

All dates for admission will be agreed with the patient. This can be either by agreeing the admission date with the patient at the time that the decision to admit him/her is made (full booking) or by asking the patient to contact us to arrange his/her admission (partial booking).

It is expected that:-

- Patients will be made a reasonable offer – that is an offer of two alternative dates with at least 3 weeks' notice for a verbal offer and three weeks' notice with one offer for a written request.
- Patients will be selected from the waiting list in accordance with the individuals' 18 week pathway.
- All patients will undergo pre-operative assessment, where required, in advance of admission.
- Wherever possible an admission date will be negotiated with the patient at the time the decision to admit is made.

13.2 Hospital Cancellations

Patient admissions should not be cancelled for non-clinical reasons at any stage. If, in unavoidable circumstances, a patient admission is cancelled on the day of admission for a non-clinical reason then they must be admitted within 28 days from the date of cancellation.

All staff holding theatre sessions should provide as much notice as possible of any planned leave. Consultants must give a minimum of 6 weeks' notice for planned leave and for any other staff theatre lists, the exigencies of the service will be interpreted as a minimum of 6 weeks' notice. There should not be any theatre cancellations or reductions for this reason without at least 6 weeks' notice. All cancellations of theatre lists that are not the result of an authorised planned absence or are within less than 6 weeks must be reported to the Operations Director who will be expected to investigate the

reason in consultation with the Clinical Director. It is important that theatre staff/schedulers do not cancel or reduce lists that are less than 6 weeks away without the authorisation of the Operations Director or Clinical Director.

- Where the patient admission has to be cancelled, the case notes should be reviewed by the clinician concerned.

- Patients that have been previously cancelled by the hospital should not be cancelled a second time.

- An alternative TCI must be agreed with the patients who would have been treated on the cancelled or reduced list as soon as possible in line with clinical need.

Short notice cancellations must be an exceptional event as they are inconvenient for patients and could possibly lead to deterioration in their health. Clinical Directors and Operations Directors will be expected to monitor the cancellation reasons and to intervene if avoidable cancellations are indicated. Where cancellations are a regular feature, actions to reduce the frequency will be agreed for each specialty and progressive reductions over time will need to be demonstrated.

Any other changes to patients' TCIs must be agreed with the patient and where possible 7 days' notice of the alternative given.

The practice of sending the patient a revised TCI without agreeing it with them or without making it clear that they can rearrange this TCI is not acceptable.

13.3 Cancer Patients

If a cancer patient cancels and rearranges three admission dates then a clinical review should be undertaken and where it is deemed clinically safe the patient should be returned to the care of their GP.

14.0 PRIVATE PATIENTS

The following guidance is taken from 'A Code of Conduct for Private Practice' published by the Department of Health in 2004 and the 'Commissioning Policy: Defining the boundaries between NHS and Private Healthcare' Reference NHSCB/CP/12 published in April 2013.

UK residents and others eligible for NHS treatment that choose to be treated privately are entitled to re-enter NHS services on exactly the same basis of clinical need as any other patient. The maximum waiting time guarantee applies to these patients as they re-enter the NHS service. Where a patient wishes to change from private to NHS status, consultants should ensure that the following principles apply: -

- Any eligible patient seen privately is entitled to subsequently change their status and seek treatment as a NHS patient.

- Any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status.

- Patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service.

Their priority on the waiting list should be determined by the same criteria applied to other NHS patients.

- If a patient is admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.

- A private outpatient consultation should not lead to earlier treatment within the NHS or earlier access to NHS diagnostic services than their clinical priority requires.

- Patients referred for NHS services following a private consultation or private treatment should be treated in the same way as a referral from any other source.

- The 18 week RTT pathway starts at the point at which the patient was referred into the NHS, not at the point they were seen privately.

- NHS patients opting to have private treatment must be removed from the NHS waiting list, their 18 week RTT clock stopped and the referral and pathway ended.

- All private patient activity must be recorded on Lorenzo EPR

15.0 PRIORITY TREAMENT FOR WAR VETERANS

When a referral for a war veteran is received, the clinicians involved their care must be made aware of this and their obligation to give the patient priority throughout their treatment. This is in line with the guidance on the treatment of war pensioners and military veterans (HSG (97)31) and 'The Armed Forces Covenant'

The guidance states that 'NHS hospitals should give priority to war pensioners, both as out patients and inpatients, for examination or treatment that relates to the condition or conditions for which they receive a gratuity, unless there is an emergency case or another case that demands clinical priority'. This covers all military veterans who require treatment for service-related conditions and not just those in receipt of a war pension. Every effort must be made by hospital staff involved in these pathways to ensure that any particular requirement for these patients is met, such as afternoon appointments or appointments on specific days.

A veteran is someone who has served in the armed forces for a least one day. When service men and women leave the armed forces, their health care is the responsibility of the NHS.

The guidance is that:-

'Where a person has a health problem as a result of their service to their country, it is right that they should get priority access to NHS treatment, based on clinical need. They should not need first to have applied and become eligible for a war pension'.

It is suggested that veterans are most likely to present with service-related conditions requiring:

- Audiology services – as a result of noise related hearing loss

- Mental Health services – these conditions may present some time after the patient has left the service

- Orthopaedic services – because of injuries during a person's time in the armed forces that begin to present problems some time after discharge from the service.

GPs are asked to identify such patients at referral. Secondary care clinicians are to prioritise these veterans over other patients *of the same level of clinical need*. Veterans should not be given priority over other patients with more urgent clinical needs.

16.0 MANAGEMENT INFORMATION

16.1 Information for Managers

Detailed information on the waiting lists is published every month as part of routine contract monitoring. More up to date information is available on the Information Services web site.

Information on the 18 week RTT pathways for specialties and individual patients is also available on the Information Services web site.

16.2 Information for Clinical Commissioning Groups (CCGs), NHS England and Department of Health

Statistical information is submitted to the Department of Health to meet statutory requirements as published in the Data Manual. The information is currently submitted via the Secondary care Data Services web based system. The information is also available to CCGs via this route. A minimum data set of all the patients on the waiting list at the end of each month is sent to CCGs.

DEFINITIONS

For the purposes of this policy, the following terms have the meanings given below:

Active Monitoring/Watchful Waiting	A clinical/patient decision is made that no treatment or further intervention is required for the time being whilst development of the patient's condition is assessed over time. The patient remains under the clinical responsibility of the consultant during this period. The clinician has to have agreed this active monitoring with the patient.
Admitted Pathway	A pathway that ends in a clock stop for admission (day case or in-patient).
Active Waiting List (Access Plan)	Patients who are awaiting elective admission for treatment and are currently available to be called for admission.
Booked Patients	Patients awaiting elective admission who have been given an admission date which was arranged and agreed with the patient at the time of the decision to admit. These patients form part of the active waiting list.
Clinical Assessment Service	A service that does not provide treatment, but assesses referrals from GP's and others to advise on the most appropriate next steps for the place or treatment of the patient.
Clinical Commissioning Groups	A group of General Practitioners who have the responsibility of commissioning care for their practice populations.
Clinician/Healthcare Professional	Allied Health Professionals (e.g. physiotherapists, dietitians etc.) Consultant and other hospital-based medical staff General Practitioners General Dental Practitioners Nurse Practitioners
Contracted Activity	The levels of patient treatments to be provided by healthcare providers, such as NHS Trusts, purchased by service commissioners, and set in the form of a legal contract.
Day cases	Patients who require admission to the hospital for treatment and will need a period of recovery, but who are not intended to stay in hospital overnight.
Decision to Admit (DTA)	Where a clinical decision is taken to admit the patient for either day case or inpatient treatment
Diagnostic Procedure	A procedure undertaken to help diagnose the patient's condition and inform the future treatment and management of that condition

Did not attend (DNA)	Patients who have been informed of their date of admission or pre-assessment (inpatients/day cases) or appointment date (outpatients) and who without notifying the hospital DNA for admission/pre-assessment or OP appointment.
Elective care	A procedure or treatment chosen (elected) by the patient or doctor that is of benefit to the patient but not urgent
E-referral service (eRS)	A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital clinic.
First Definitive Treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention.
Full Booking	Full booking is where the offer of appointment or admission date is agreed with the patient at the time the offer is made.
Lorenzo EPR	Trust electronic patient record system incorporating administration functions
Incomplete Pathway	A pathway where patients are waiting to start treatment and where the 18 week clock is still running at the end of any reporting period
Inpatients	Patients who require admission to hospital for treatment and are intended to remain in hospital for at least one night.
Inter-Provider Transfers	A referral from another healthcare provider other than STHFT
Minimum Data Set	National data sets which define a standard set of individual data items from information generated from patient care records
Monitor	Independent regulator of NHS Foundation Trusts
Non-admitted Pathway	A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.
Partial Booking	Partial booking is where we ask the patient to contact the hospital to agree an appointment date and time or admission date.
Patient Administration System (PAS)	Patient Administration System – currently known as Lorenzo EPR
Patient Pause	An allowable pause in the patient pathway in certain circumstances, initiated by the patient. Please note this no longer adjusts the RTT waiting time and the clock remains ticking

Planned Admissions	Patients who are to be admitted as part of a planned sequence of treatment or investigation. The patient has been given a date, or approximate date at the time a decision to admit was made. These patients do not form part of the active waiting list.
Pre-documentation (Pre-doc)	Entry of patient details onto hospital computer system at the time of receipt of referral in advance of patient appointment offer.
Referral	Documentation used to seek clinical advice or treatment for a patient.
Referral Management Centre	A service that does not provide treatment, but assesses referrals from GP's and others to advise on the most appropriate next steps for the place or treatment of the patient.
Referral to Treatment (RTT)	The time from referral to first definitive treatment for a single condition.
Service Commissioner	Organisations responsible for purchasing healthcare services for the local or national populations.
Social/Personal Suspension	Patients who have asked for their admission to be delayed for social/personal reasons
Service Provider	Organisations responsible for providing healthcare services for local or national populations.
The Appointment Line (TAL)	A telephone booking service for patients to book, check, change or cancel their appointments via e-Referral Service
To Come In (TCI) Date	Date set for patient's admission to hospital
Therapeutic Procedure	A procedure undertaken to help treat the patient's condition

Appendix 1

Outpatient Clinic Outcome Form

APPENDIX 2

INITIAL EQUALITY IMPACT ASSESSMENT PROFORMA FOR POLICY

POLICY: ACCESS POLICY - Managing the 18 Weeks Referral to Treatment Waiting Times

Who has been consulted?
Elective Care Working Care
Waiting Times Performance Overview Group Service Managers
Trust Executive Group
NHS Sheffield and associates
Accountable Care System Elective Care Workstream

Describe the aims, objectives and purpose of the policy service being assessed:
Ensure that patients access to health care is fair and consistent and in line with national waiting times rules.
Who is intended to benefit?

Patients and Staff

Equality Impact Analysis <u>Screening Tool</u> – Written Policy or Guidance

	- Is there a potential or actual negative impact associated with this policy on people or individuals who share a 'protected characteristic'? i.e. does this policy directly or indirectly discriminate? - Can this policy be used to promote equality between people who share a protected characteristic and people who do not	**NOTES** changes/additions/ further information or advice needed

RACE	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
SEX (I.E. MALE / FEMALE)	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
GENDER REASSIGNMENT	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
DISABILITY(including consideration of the impact on carers of a disabled person)	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
RELIGION OR BELIEF	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
SEXUAL ORIENTATION	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
AGE	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
PREGNANCY or MATERNITY	Neutral impact	This policy applies equally to all patients, their carer's and staff.
	Does this Written Policy or Guidance	**NOTES**

	impact on the following areas?	changes/additions/ further information or advice needed
HUMAN RIGHTS i.e. **Fairness** **Respect** **Equality** **Dignity** **Autonomy**	The policy implicitly and explicitly supports all of these principles and promotes equality of access throughout.	
SOCIAL DEPRIVATION / TACKLING HEALTH INEQUALITY	Neutral impact	This policy applies equally to all patients, their carer's and staff.